

MEDICAL RECORDS RELEASE



Today's Date \_\_\_\_\_

I hereby authorize Obstetrics & Gynecology Associates, Inc. to:

**RELEASE MY ENTIRE MEDICAL RECORD TO:**

Physician, Facility, or Self: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Reason for Release:**

\_\_\_\_ Specialist Appointment (Please specify date) \_\_\_\_\_

\_\_\_\_ Leaving Practice (Please specify reason) \_\_\_\_\_

\_\_\_\_ Other (Please specify reason) \_\_\_\_\_

\_\_\_\_ At the request of the individual

**-OR-**

**OBTAIN FROM:** Physician or Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

I understand that my records may contain information regarding the diagnosis or treatment of HIV, Aids virus, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released:

- € HIV/AIDS
- € Sexually transmitted diseases
- € Mental illness or mental health treatment
- € Drug and alcohol abuse treatment

Patient's Name (print) \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient's Signature \_\_\_\_\_

**Please note:** There is a retrieval fee of \$18.91 for any records having to be obtained from our off-site storage facility. Payment of this retrieval fee will be due prior to the retrieval of your records. There will also be a charge for a subsequent copy of medical records. We suggest you make a copy of your records prior to releasing them to another physician.

Please allow 3 business days for electronic transmission and up to 14-21 business days to receive your paper chart records.

**3050 Mack Road, Suite 375 Fairfield, OH 45014 phone (513) 221-3800 fax (513) 682-4520**